SOME CLINICAL OBSERVATIONS ON THE PSYCHODYNAMIC RELATIONSHIP BETWEEN DEPRESSION AND OBSESSIVE-COMPULSIVE SYMPTOMS.*

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OBSESSIONAL symptoms and depression often co-exist. There are obsessional neurotics who are subject to recurrent depressions, and there are patients with marked obsessional personality features, but not suffering from an obsessional neurosis, who develop severe obsessional symptoms in the course of their depressions only. I do not agree with those writers who maintain that the typical features of the obsessional character can be found in every case of manic-depressive illness.

The study of the interaction between obsessional and depressive symptoms gives rise to a number of problems. The following two questions are of particular importance to the psychiatrist interested in psychodynamics: What is the fate of the obsessive-compulsive symptoms in the course of the depression? And secondly, does depression occurring on the background of obsessional neurosis differ from the typical depressive state? The most striking feature in many of those cases is the exacerbation of the habitual obsessive-compulsive symptoms during the depression and the emergence of new ones, usually with overt obsessive-destructive contents. The impulses are, during the course of the depression, much less subjected to secondary elaborations, such as over-compensation, displacement, symbolization and sublimation, than is the case in the typical obsessional neurosis. Those mechanisms tend to break down in the course of the depressions, and compulsions directed against external objects and the self appear undisguised and sometimes come precariously near to real action. The newly emerging obsessions are, as a rule, centred around the same complexes as are the habitual symptoms; e.g. a patient who had for many years been suffering from the compulsion to inspect the gas and water taps several times every evening lest his family may be drowned and gassed had periods of depression lasting for six months, during which the fear of having to murder his wife and child was the most prominent symptom. That compulsion had emerged only after the depression had been present for a week. It subsided completely with the depression. This is the type of case that is often diagnosed as recurrent or cyclical obsessional neurosis. In those cases the habitual obsessional symptoms which had been present for a long time prior to the depression are not always easy to ascertain during the depression, which is overshadowed by the much more spectacular recent obsessions.

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There is another feature which colours the depressive symptoms of the obsessional. It is the well-known tendency to doubt which makes the patient take up a critical attitude towards his ideas and even to his pathological mood. While the typical obsessional neurotic is preoccupied with the fear of doing wrong and with precautions against such impulses, and while the typical depressive patient is convinced that he has sinned, the obsessional going through a period of depression tortures himself with the fear that he may have done wrong in the past. The self-accusations often take the form of phobias projected into the past. They show a tendency to spread like obsessional ideas, and the patient would take obsessional precautions against them. An obsessional woman who, in her depressions, tortured herself with the fear that she might have done harm to a child many years ago, and accused herself of acts which she knew she had never committed, had worked out a ritual of avoiding children, with the professed purpose of not giving food to those self-accusations. Her attitude towards them was similar to that of the obsessional neurotic to his obsessions. In many of those cases the depressive mood does not dominate the clinical picture. Some psychiatrists are inclined to regard the depression in those cases as a natural reaction to an exacerbation of the obsessional illness. A variety of clinical facts which I pointed out some time ago (1) argue against such an explanation.

In studying those cases it becomes obvious that the obsessional personality structure has a modifying effect on the mechanisms of pathological depression. It tends to counteract regression to the deepest sadistic level, and to prevent a complete break with reality. Part of the aggressive impulses, which in the typical depression are mainly directed against the self, are diverted against external objects. Those impulses are subjected to the brake of obsessional ambivalence. Thus the obsessional personality structure exerts an integrating and preserving influence in a situation charged with enormous tension. We recognize the stabilizing effect of the obsessional personality structure which Glover (2) aptly called its buffer function. That effect can be demonstrated even more clearly in the interaction between obsessional and schizophrenic manifestations. Here we can study in action one of the " modifiers " postulated by Professor Kallmann (3) from the genetic point of view. Whether, in an individual case, such a modifying influence makes itself noticeable clinically must depend on quantitative factors.

If we take into consideration the two mechanisms which I have tried to demonstrate, namely the aggravating and unmasking effect of depression on overt and latent obsessional symptoms and the integrating influence of the obsessional personality structure on the depression, we shall, I think, arrive at a better understanding of some atypical clinical conditions often classed among borderline states. The majority of cases of so-called cyclical obsessional neurosis may become clearer and their spontaneous recoveries may appear less unexpected if we search closely for symptoms of depression and for a history of obsessional features.

The kind of interaction which I have just described is not the only one, but it is the most common. There are other forms of modification of depression by the obsessional neurosis and personality structure which I can only mention

briefly. There is one in which the habitual obsessions fade into the background during the course of the depression, which is characterized by marked aggressive behaviour, and another in which the depression becomes a masochistic orgy. In both those cases the symptoms are coloured by doubts.

In the few minutes at my disposal I could not give more than a rough sketch of some clinical observations which demonstrate the importance of the psychodynamic approach for symptomatology and diagnosis. These important aspects of clinical psychiatry will have to be cultivated again, if only to enable us to compare notes and to understand each other's language. It often seems that in our zeal for explaining and treating mental illness we are in danger of losing sight of what we are trying to explain and to cure.

References.

1) Stengel, E. (1945), *J. Ment. Sci.*, **91**, 166.
(2) Glover, E. (1932), *ibid.*, **78**.
(3) Kallmann, F. J. (1946), *Am. J. Psychiat.*, **103**, 309.